PRESCRIPTIONS for PROGRESS

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EDITORIAL

Why Read This Newsletter?

HUGHES

Edward F. X. Hughes, MD, MPH, Professor of Management and Strategy, Professor of Health Industry Management, Kellogg School of Management, Northwestern University

YOU'RE VERY BUSY. ON ANY AVERAGE DAY YOU'RE DROWNING IN PAPER. You have a large and complex system to oversee. So, why should you take any of that valuable time to read this newsletter? We accept that question as both logical and appropriate for someone in your position. We hope you will take time to see if our answers hold true for you.

First, this newsletter was designed with specific audiences in mind: public administrators of Medicaid programs, especially pharmacy services, mental health leaders in state and county government, community providers, and concerned mental health advocates, family members, and consumers.

Second, the editorial review board is composed of people who have lived in your world: 3 former state and local mental health executives; a former state Medicaid director; 2 current Medicaid pharmacy directors; a policy advocate for people with mental illnesses; several mental health researchers whose work focuses on complex, real-world implications of policy and financial decisions; and a consultant in private sector benefit management. My own years as a physician and educator with a focus on management and health policy have made me keenly aware of the demands on public leaders like you.

Third, we have made a commitment to keep the articles brief, informative, and straightforward. Although we will build the articles on solid science, we don't intend for this to be an academic journal. We want it to be accessible.

Fourth, we think you will be interested in the financial information about the states from Standard & Poor's (a division of The McGraw-Hill Companies) that is included in every issue, because the economic health of your state can impact immediately on the range of choices open to you in your efforts to serve very vulnerable people.

And finally, we want to respond to issues that are of concern to you. If you have ideas about how to improve *Prescriptions for Progress* please let us know.

I am pleased to partner with McGraw-Hill Healthcare Information Group and Comprehensive NeuroScience, Inc., to bring current critical matters to your attention, and am grateful to Eli Lilly and Company for their unrestricted sponsorship of this effort.

Enough said: We hope that when you finish this initial issue, you will agree with our reasons why you should read *Prescriptions for Progress* and that you will look forward to future issues.

MAKING A VISION REAL:

Giving Life to This Newsletter

DID YOU KNOW?

During the past 2 decades there have been important shifts in what parties have final responsibility for paying for mental healthcare. The role of direct state funding of care has been reduced, whereas Medicaid funding of mental healthcare has grown in relative importance.

Source:
Mental Health: A Report of the Surgeon General

THE CHALLENGES OF MANAGING PUBLIC SAFETY-NET PROGRAMS are truly daunting. Working as a Medicaid or mental health executive—while often rewarding—can be a thankless task. Advocates for improved services can never let their eyes off the ball. One is constantly weighing competing elements: the health status of vulnerable populations, increasing healthcare costs, rapidly changing technology, state budget fluctuations, and changes in federal policy. And all of this played out on a public stage in the context of state and federal policy—and politics.

This newsletter was designed to provide an independent source of information and advice. The partners in this effort, Comprehensive NeuroScience, Inc., McGraw-Hill, and Dr Ed Hughes of the Kellogg School at Northwestern University, all recognize that people in these complex roles suffer from extreme time pressure, and need brief, relevant, and reliable information.

SURLES

Richard Surles, PhD, Senior Vice President of Comprehensive NeuroScience Inc, Former State Commissioner of Mental Health in Vermont and New York

If your response to our effort is what we hope it will be, we plan to publish *Prescriptions for Progress* 4 times a year. We have put together an impressive editorial board, whose members will contribute useful, thoughtful articles on timely topics. To create this newsletter, we used an "expert roundtable" methodology to take an environmental scan. The roundtable group met for a full day of discussions at the Allen Center of the Kellogg School of Management at Northwestern University; the day was a mix of brief presentations by the experts in attendance on key issues, interspersed with lively discussion and debate.

Several people involved in this process have spent time in roles as city, county, and state agency executives. I believe all of us consider ourselves advocates for people with mental illnesses. The reality is that the number and complexity of issues in behavioral health and pharmaceutical benefits are expanding expo-

Richard Surles and Chris Koyanagi listen during the roundtable.

nentially. New studies, new compounds, new concerns emerge daily. It is hard for any one of us to stay current.

The experts at the roundtable and participating in this newsletter include:

- Bridget Eber, PharmD, National Pharmacy Practice Leader, Hewitt Associates
- Chris Koyanagi, Policy Directory, Bazelon Center for Mental Health Law
- Kit N. Simpson, PharmD, Professor, Medical University of South Carolina
- Richard G. Frank, PhD, Professor of Health Economics, Harvard University Medical School
- Trevor Hadley, PhD, Director, Center for Mental Health Policy & Services Research, Professor of Psychology in Psychiatry, University of Pennsylvania
- Edward F. X. Hughes, MD, MPH, Professor of Management and Strategy, Professor of Health Industry Management, Kellogg School of Management, Northwestern University
- Gary Gilmore, RPh, Deputy Pharmacy Director/Chief Analyst, Massachusetts Medicaid Office of Clinical Affairs
- Greg Vadner, MPA, Former Director, Missouri Division of Medical Services
- George Oestreich, PharmD, Director of Pharmacy Program, Missouri Medicaid Department of Social Services
- Colette Croze, MSW, Principal, Croze Consulting
- Richard Surles, PhD, Senior Vice President of Comprehensive NeuroScience, Inc, Former State Commissioner of Mental Health in Vermont and New York
- Jim Dougherty, Group Vice President for the Healthcare Information Group at The McGraw-Hill Companies
- Claudia Gerigk, Associate Director, Office of Research, Comprehensive NeuroScience, Inc
- John Morris, MSW, Professor, University of South Carolina School of Medicine, Senior Policy Consultant for Comprehensive NeuroScience, Inc, Former state mental health executive, South Carolina

Although we will focus primarily on pharmacy benefits, we will also look at major national policy issues that will have significant impact on behavioral health and Medicaid policies; the changes in 2006 policies for Medicare are a prime example.

Here is a partial listing of issues that will be highlighted in future issues of the *Prescriptions for Progress*:

- How to strike a balance between minimum cost and maximum effectiveness
- How physicians and patients can talk about the costs of drugs
- How we can continually improve prescribing practices
- The role of diagnosis: wrong diagnosis = wrong algorithm.
- Case studies from the real world

We hope you will help us make this an effective publication by giving us your feedback. Please contact the Editor, John Morris via email at jmorris@cnsmail.com with comments and suggestions.

DID YOU KNOW?

In 1997, the latest year comparable data are available, the United States spent more than $1 trillion on healthcare, including almost $71 billion in treating mental illnesses. Mental health expenditures are predominantly publicly funded at 57%, compared with 46% of overall healthcare expenditures.

Source:
Achieving the Promise: Transforming Mental Health Care in America, final report of the President's New Freedom Commission (p.3)

AN INTERVIEW WITH BRIDGET EBER, PHARMD

Private Sector Strategies for Managing Pharmacy Benefits

INTERVIEW BY:
John Morris, MSW, Professor, University of South Carolina School of Medicine, Senior Policy Consultant for Comprehensive NeuroScience, Inc, Former state mental health executive, South Carolina

DID YOU KNOW?

The higher than average growth rate (almost 10%) of spending for prescription drugs reflects, in part, the increasing availability and application of medications of demonstrable efficacy in treating mental disorders.

Source:
Mental Health: A Report of the Surgeon General

EBER

Bridget Eber, PharmD, National Pharmacy Practice Leader, Hewitt Associates, a global human resource outsourcing and consulting firm

BRIDGET EBER, PHARMD, IS THE NATIONAL PHARMACY PRACTICE LEADER for Hewitt Associates, a global human resource outsourcing and consulting firm. From the firm's headquarters in Lincolnshire, Illinois, Bridget leads a team that develops strategies and implements programs to help large employers provide cost-effective prescription drug benefits to their employees and dependents. The pharmacy practice conducts projects in the areas of plan design, market bidding and selections, implementation, administrative services organizations contract review, pharmacy benefit management (PBM) audit, and assessment of operations and cost management programs. Prior to her current role, Bridget practiced as a pharmacist and held teaching roles at the University of Illinois, Northwestern Memorial Hospital, Department of Veterans Affairs, and Chicago Medical School. She speaks frequently and has published a number of articles in the area of pharmacy cost management.

EDITOR: Bridget, we invited you to lead off the recent Expert Roundtable because we wanted to start with an overview of the techniques that private sector benefit managers use, to see both the strengths and potential pitfalls of translating those techniques into public sector behavioral pharmacy. We thought our readers would like to get some of that same information, which the participants in the roundtable found very useful.

EBER: In thinking about this issue, it's important to understand the steps that we would take in a private sector environment and then translate them into the special challenges that Medicaid and state mental health authorities may face when they try to build a benefit package for vulnerable public populations. State restrictions on copays and formularies are just a few of the limitations placed in Medicaid plans versus the private sector.

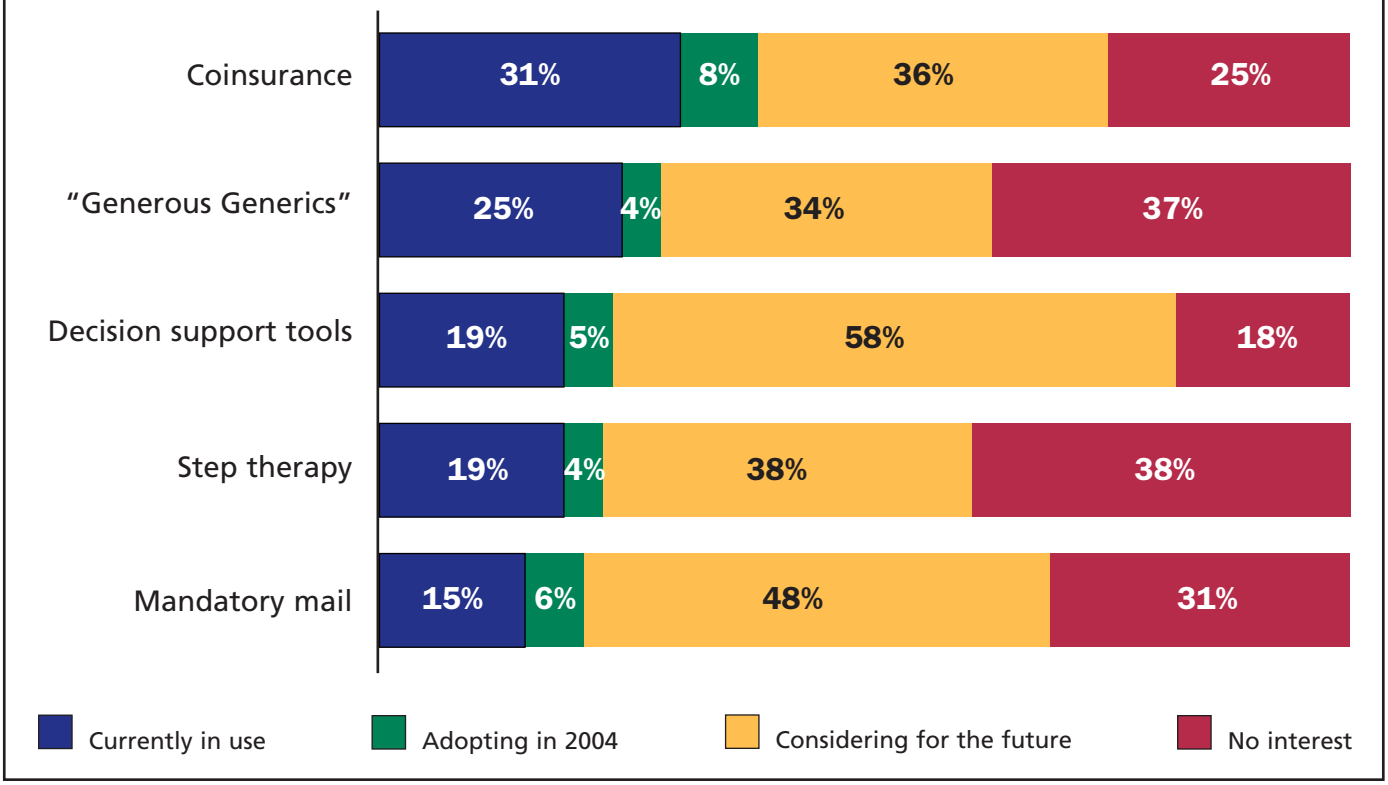
Employers follow a strategy that consists of 4 interdependent phases, and most of the components translate in theory from private to public policy environments: In the following material, I will briefly review each of the phases:

1. Plan design
2. Pharmacy Benefit Management (PBM) procurement
3. Cost management
4. Specialty pharmacy planning

EDITOR: Let's start with plan design. Can you give us some details about what sorts of things are involved in designing a plan?

EBER: Employers implement a number of different plan design strategies, ranging from "leading edge" to conservative. To help us keep track of the initiatives, Hewitt conducts an annual survey that is designed to assess strategies that are in use for the majority of self-funded pharmacy benefits. In 2004, the survey reached approximately 1,000 employers and achieved a 65% response rate. The survey identified 5 strategies that are currently the most popular for designing pharmacy benefit management (table 1). They are: coinsurance, "Generous Generics," decision support tools, step therapy, and mandatory mail programs.

TABLE 1. EMPLOYERS' MOST COMMON PHARMACY PLAN DESIGN STRATEGIES 2004



SOURCE: Health Care Expectations Survey 2004. Hewitt Associates; 650 large employers.

Coinsurance

Coinsurance means that the members would pay a percentage of the covered charges, for example 20% to 30 %. Coinsurance is in contrast to copayments. With a copayment design, the members out-of-pocket costs would be fixed at some dollar amount—for example, $10 regardless of the covered charges. The perceived advantage to coinsurance design is that a low-cost pharmaceutical would cost the member a lower amount out-of-pocket compared with a high-cost pharmaceutical. Because many employers feel that it is a consumer's right to know about their conditions and the various treatment options, coinsurance may provide a catalyst for members to engage in conversations about their health and the affordability of medications.

Generous Generics

Generous Generics means that the member would pay a small copayment for generic drugs (for example, $2) and the member would pay a coinsurance for brand name drugs (for example, 30% of the cost). Many times employers will place a maximum brand copay so that members can still have affordable access to expensive specialty drug products. The perceived advantage of the predictable low copay for any generic drug is a likely increase in utilization of therapeutically equivalent generics and a resulting decrease in employers' drug spend.

Decision Support Tools

Decision support tools refers to the information that enables employees' right to know about the medications that doctors prescribe for them. Employers are sponsoring a variety of Web-based tools and print media that are designed to identify the employees' costs associated with their prescriptions. If a less costly but therapeutically equivalent drug is available, the tools will identify those alternatives and send a message to the physician identifying the alternative.

Step Therapy

Step therapy refers to a set of adjudication edits that denies a claim for a second- or third- line pharmaceutical only when the patient's drug claim history does not contain the use of a first-line drug. If there are no records for a first-line drug, then the claim would be denied. Step therapy edits have increased in frequency over the recent past to

manage the utilization of high-cost medications. Drugs used to treat allergies, arthritis pain, and hypertension are often prime candidates for step therapy programs.

Mandatory Mail

Mandatory mail refers to a plan design in which the employer covers refills of maintenance medications only if the member uses the plan's mail order pharmacy. Refills of maintenance meds filled at the retail pharmacy would not be eligible for coverage. The perceived advantage of Mandatory Mail is a steeper discount for mail compared with retail.

Emerging Strategies

In addition to the 5 previously mentioned strategies, the survey identified other strategies that are emerging as design tools (table 2):

1. Explanation of benefits (EOB)
2. Therapeutic maximum allowable cost (MAC)
3. Customized design
4. Health reimbursement accounts (HRA) for prescriptions
5. Copay waivers

Some of these probably have no applicability to disability or publicly insured populations, but others may have utility. I can address some of these in detail later.

Explanation of Benefits

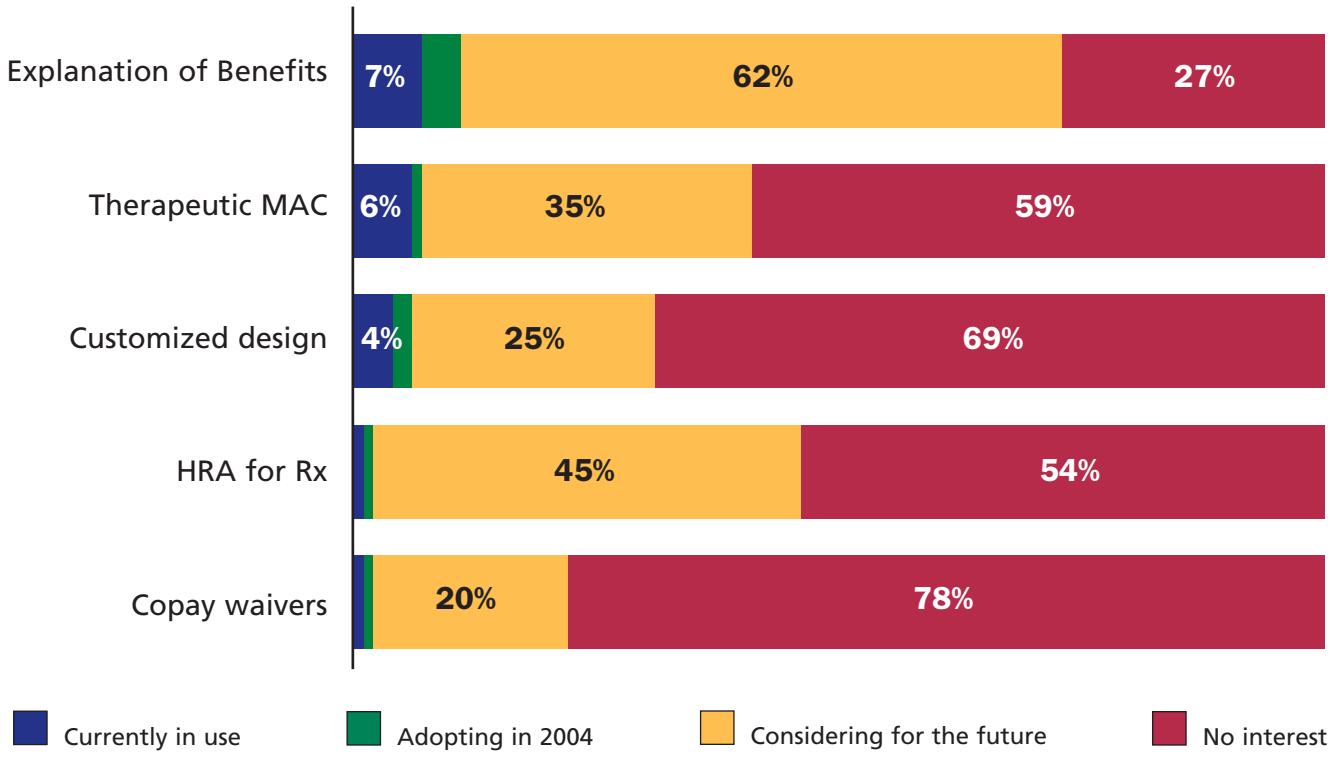
Explanations of benefits (EOB) means a statement identifying the prescription drug claims and the amount the company paid for that drug. If a less costly drug were available, then the EOB would contain a message indicating such. The perceived advantage to EOBs is the concise nature of the document and information about the company's costs and the members' costs.

Therapeutic MAC

Therapeutic MAC means a coverage policy related to prescriptions that treat the same conditions, ie, therapeutic equivalents. MAC means "maximum allowable cost," which is a fee schedule typically used to identify employers' costs for generic drugs. Based on the evidence-based treatment guidelines and financial distributions of cost by therapeutic class, the company would pay up to a certain amount, ie, the MAC for any drug prescribed to treat the condition. For prescription costs at or below the MAC, employees would pay $0; however, if

SOURCE: Health Care Expectations Survey 2004. Hewitt Associates; 650 large employers.

TABLE 2. EMPLOYERS' EMERGING PHARMACY PLAN DESIGN STRATEGIES 2004



Bridget Eber, PharmD, explains popular strategies for pharmacy benefit management.

the prescription costs above the MAC, the member would pay the difference between the covered charges and the MAC.

Customized Design

Customized design means that the employee would select a prescription drug plan design from a set of options at the time of enrollment. Monthly payroll deductions would vary based on the richness of the plan. The perceived advantage of this strategy is to allow members to have a choice of pharmacy plans.

HRA for Prescription Drugs

HRA means Health Reimbursement Account, and an HRA for prescription drugs means that the prescription plan would have a high deductible followed by a coinsurance design. Once a member reaches an out-of-pocket limit, then the plan would cover 100% of the covered charges.

Copay Waivers

Copay waivers means that an employer will cover the full cost of certain prescriptions. Typically, employers will waive every third copay as an incentive to promote medication compliance or enrollment in a disease- or condition-management program.

EDITOR: OK. How about procurement issues for pharmacy benefit management (PBM)? Can you give us a quick overview, and perhaps make the distinction between public and private sectors?

EBER: Procurement decisions are always high-impact ones for private sector purchasers. Currently, employers are scrutinizing the PBM vendors in several areas of transparency.

1. Margins between their retail pharmacy contracts and their employer contracts vary because many PBMs currently purchase prescriptions from their network pharmacies at a different discount and dispensing fee than the discounts and dispensing fees that they quote to employers.
2. Drug specific rebates applied at the point-of-sale because employers want the true net cost of the prescription to be reflected

when the claim is adjudicated as opposed to receiving a check 12 to 18 months later.

3. Full and fair administrative fees that align the cost management incentives between PBMs, employers, and pharmaceutical manufacturers.
4. Cost management-performance guarantees that mandate specific savings targets that are directly attributable to improving/optimizing cost efficiency of drug mix and that include penalties for failure to achieve them.

What I have outlined above is based on my experience in the private sector, but as several expert roundtable members with significant public sector experience noted, Medicaid and mental health agencies have additional hurdles that they have to contend with because of state procurement regulations and stringent oversight requirements for bidding and negotiating. They also note that, other than consideration of supplemental rebate, all 50 states get the benefit of the lowest commercial contracts available equally. They remind us that public administrators (including those who manage health and behavioral health services in such non-Medicaid environments as prisons) work in a fishbowl environment that causes successful administrators to carefully balance risk and innovation in all major decisions.

So the private sector process of negotiating is quite different from the more constrained public procurement process. But that being said, I think there are some basic principles that apply across sectors if a Medicaid agency or other public payer chooses an external pharmacy benefit manager.

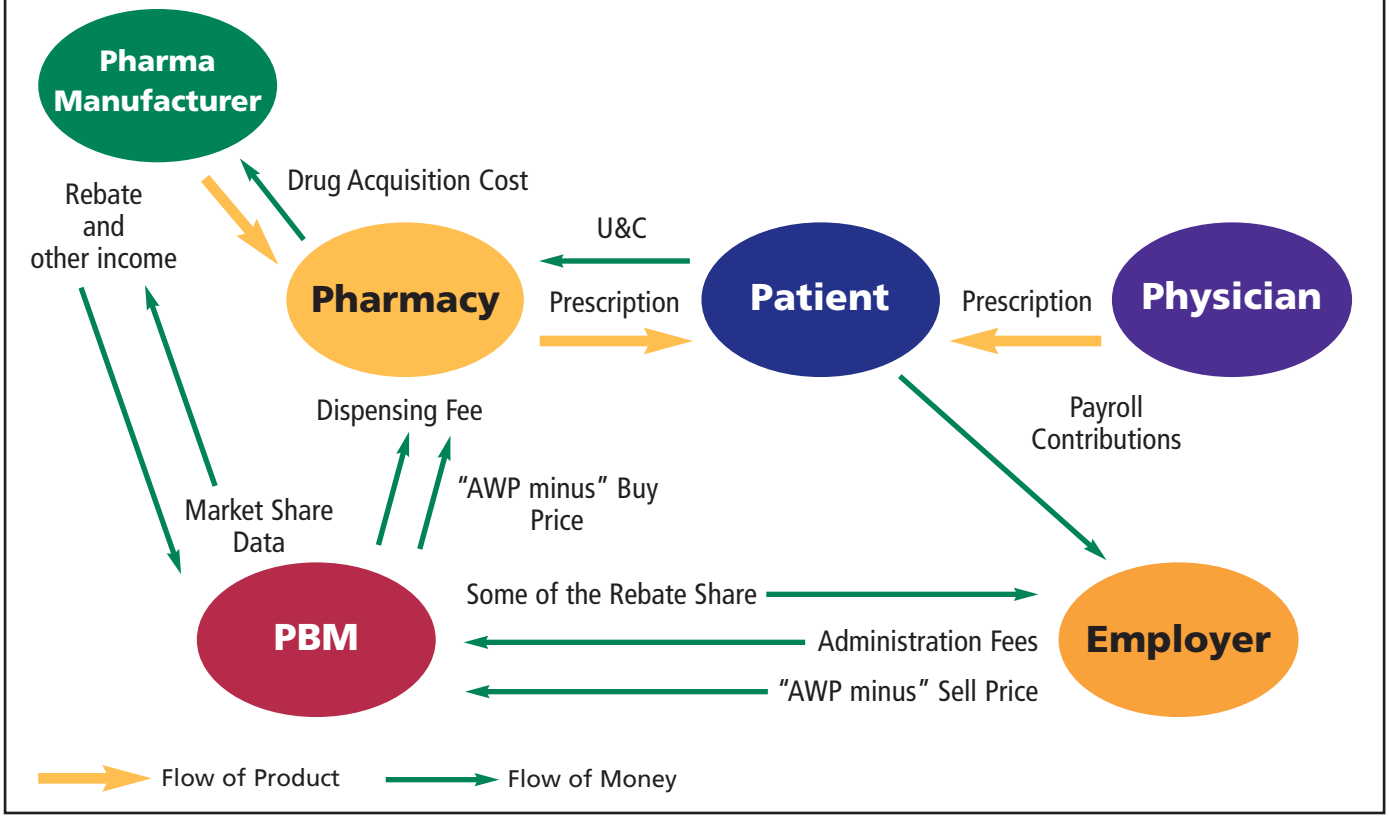
EDITOR: Next is cost management. You have identified some basic principles of drug cost management that will be of interest to our readers.

EBER: Yes, there are some fundamental principles at work here.

- The first is that we need to maximize drug utilization cost efficiency. Generally, there are just a few conditions that drive the bulk of demand, and the balance of high-cost and low-cost drug distribution drives cost efficiency of the drug mix. Traditionally, PBMs have taken a conservative approach to managing costs for employers by limiting their interventions to rebate contracting

Both Bridget Eber, PharmD, from the private sector, and Ed Hughes, MD, MPH, from the senior academic realm, offer valuable insights.

FIGURE 1. THIRD PARTY PAYERS CREATE ECONOMIC COMPLEXITY



SOURCE: ©Hewitt Associates LLC. Reprinted with permission.

with manufacturers. Many employers feel that the rebates represent a cost management myth because the strategy is almost entirely focused on the brand name drugs that are often advertised directly to consumers.

The new trend in cost management is to assess the utilization of the generic drugs and brand name drugs that are not advertised on television, and require the PBM to implement and support programs that are designed to create a more favorable drug mix.

- Secondly, the employers want their PBMs to fully support clinical programs by establishing a productive relationship with doctors, and providing evidence-based information that will support a prescribing pattern that is more cost efficient.
- Thirdly, employers want their PBMs to profile retail pharmacies that will identify those whose generic dispensing rates are above average. For those high-performing pharmacies, many employers are willing to offer coupons to their members as a way to encourage their utilization.
- Fourth, employers want their PBMs to offer more decision support tools so that members can be better prepared to understand the treatment options for their conditions and talk to their doctors about the medicines that are most affordable for them.

So, for most employers, just having a PBM that delivers a net discount off the pharmacy price doesn't guarantee maximization of drug cost utilization. The plan must be tailored to improve cost efficiency for common conditions—with performance guarantees that are closely monitored, at least on a quarterly basis.

EDITOR: Hewitt Associates has something called the Value Drug Report Card. Can you tell us about how that works?

EBER: Sure. We believe that "value drugs" are the most clinically cost-effective drugs to successfully treat a given condition (ie, generics and low-cost drugs that yield positive clinical results). Our experience is that many companies spend too much on drugs because value drugs are not prescribed often enough. We actually assign a letter grade—hence the "report card"—to drugs for key conditions, and this helps us identify savings opportunities.

If a company is purchasing drugs with a failing grade, then they are missing opportunities to improve their cost efficiency.

Here is an example Value Drug Report Card. The report card is helpful to a pharmacy manager in 3 ways:

1. The Value Drug Report Card identifies the population's most common conditions as identified by the drug utilization
2. It quantifies the cost efficiency of the drug mix for each condition
3. It models achievable savings targets if conditions were successfully managed with a more cost-efficient drug mix

Example Value Drug Report Card

Using high cholesterol as an example, this employer is spending $3.7 million and their value-drug dispensing rate is less than 1%. If this employer's drug utilization for statins were optimized, the drug spend would be reduced to $2.3 million which translates to $1.4 million in savings (37%).

Our experience with the private sector suggests that commercial pharmacy benefit managers have not focused on "lowest net cost" for each condition unless the employer specifically identifies performance goals in this area. Contracted rebates for certain high-cost brand name drugs are helpful in reducing costs between 2% and 7% of drug spend; they do not deliver the same outcome as a significant change in drug mix.

Employers and their PBMs have not been able to design a clinical cost management program that leverages treatment guidelines along with financial management goals. We believe that a tool such as the Value Drug Report Card identifies the conditions where financial management is most strongly required, and it provides the employer with a specific performance measure with which to assess the success of their PBM total cost management programs.

EDITOR: You have also given attention to the issue of specialty pharmacy. Can you briefly address the special concerns here?

EBER: Specialty pharmaceuticals are also called "biotech" or "genetically engineered" drugs, and they are typically injectable drugs that may not be available in other pharmacies. Managing specialty pharmaceuticals is a hot topic right now because the pipeline of new biotech drugs is bursting, and they are very costly—up to several thousand dollars per member per year.

Employers are currently developing strategies in 2 main areas. First, employers are

SOURCE: ©Hewitt Associates LLC. Reprinted with permission.

TABLE 3. VALUE DRUG REPORT CARD

CONDITION	GRADE	ACTUAL COST	(PMPM)	TARGETED COST	(PMPM)	SAVINGS OPPORTUNITY
High cholesterol	F	$3,704,724	($10.24)	$2,329,400	($6.42)	$1,380,784
High blood pressure	D	$3,055,072	($8.45)	$2,541,641	($7.03)	$513,431
Ulcers and heartburn	F	$2,081,103	($5.75)	$1,798,630	($4.97)	$282,473
Depression	F	$1,397,786	($3.86)	$1,157,400	($3.20)	$240,387
Diabetes	F	$1,307,328	($3.61)	$914,577	($2.53)	$392,751
Infection	F	$1,287,960	($3.56)	$838,558	($2.32)	$449,402
Arthritis	F	$1,178,691	($3.26)	$815,830	($2.26)	$362,861
Severe pain	C	$1,028,823	($2.84)	$563,085	($1.56)	$465,738
Birth control	D	$301,120	($0.83)	$270,432	($0.08)	$30,688
"All other" conditions	F	$13,347,151	($36.90)	$8,586,705	($23.74)	$4,760,446

- Value drugs are the most clinically cost effective drugs (generics and low-cost brands) for a given condition.
- For most companies, drug spend is too high because value drugs are not prescribed often enough.
- The to differentiate among PBMs is drug utilization cost efficiency.

PMPM, per member per month; PBM, pharmacy benefits manager.

requiring their PBMs to perform a prior authorization before a claim determination is made. The process typically requires a review of medical records and a manual override in the PBM adjudication system. If a member's condition does not meet the established clinical criteria, then the claim is denied. If the member's condition meets the criteria, then employers can feel comfortable that their costs are being allocated where they are most needed.

Second, the distribution channel is another area where employers are developing strategy. Because many of these drugs are injectables, members have several options for obtaining the treatments that include their doctors, their retail pharmacies, and their PBM's specialty pharmacies. Although the PBM's specialty pharmacy may offer a more aggressive discount than the doctors or the retail pharmacies, members may be accustomed to obtaining the drug from the doctor. If the doctor is unaware of a payer's decision to use a PBM outlet, disruption can be an issue and the member would be in the middle and may not be able to receive his drug in a timely fashion.

Because many of the specialty pharmaceuticals are injectable and indicated for oncology cases, there have been interruptions with care if the parties do not coordinate the supply chain and the payment mechanisms.

EDITOR: This is a great overview. Would you highlight a few of the design features you briefly identified at the beginning of our interview, with a special view toward psychiatric medications that our readers will have special concerns about?

EBER: Sure, with regards to psychiatric medications, many employers are hesitant to apply clinical cost management programs for drugs that are indicated for severe conditions such as psychosis, bipolar disorder, and neurologic conditions such as seizure. Employers would apply the majority of programs that I described in the earlier section of this article to chronic conditions that are typically treated by internal medicine specialists.

Employers are, however, committed to promoting condition management and wellness initiatives when it means better care productivity for their employees. In the area of behavioral health, for example, employers are not likely to place restrictions on access to drugs through strict formularies or prior authorization edits. Instead, employers are more likely to establish a contract with a behavioral health management vendor who would be responsible for integrating the many facets of the healthcare delivery system. Compliance with medications is at the forefront of the performance metrics, and probably many of the readers are familiar with the significant literature about the importance of adherence to treatment regimens for people with psychiatric disabilities.

EDITOR: Are there some final points that you'd like to make that would summarize this for our readers?

EBER: First of all, there is no automatic correlation between cost and quality for pharmaceuticals. At least in the private sector, plan design options are providing significant incentives for members to manage costs by aligning members' out-of-pocket costs more closely with the true net cost of the prescription. This may or may not have applicability to publicly ensured enrollees given the fact that most Medicaid recipients (or Medicare beneficiaries under 65 by reason of disability) are poor. But certainly public purchasers should be focusing on aligning incentives to maximize the effectiveness of drug utilization. In an era of state budget reductions, it is more important than ever that we take approaches that allow us to manage conditions and reduce costs by using drugs that provide maximum value for their cost. That means we should focus on affordability only if all of the treatment options are clinically comparable. The core focus, of course, needs to be on effectiveness and performance.

While I have focused a lot on costs, the net result of effective utilization (remembering that this concept includes positive clinical outcomes) is that it can free up resources to serve more patients. That reinvestment decision is one that each state will have to make.

EDITOR: Thanks for your contributions to this discussion. If our readers want more information, can they contact you?

EBER: Yes, readers may contact me at bridget.eber@hewitt.com or via phone at (847) 295-5000.

DID YOU KNOW?

MEDICAID SPENDING

Prescription drugs are consuming a growing share of Medicaid dollars, accounting for 10% of Medicaid spending. Moreover, Medicaid spending on prescription drugs has increased 18% annually for the last 3 years.

Source:
NAMI Web site

STANDARD & POOR'S

Not-For-Profit Heathcare Ratings Actions

DID YOU KNOW?

Healthcare costs can have a significant impact on corporations, states, and municipalities. These costs may ultimately affect a credit rating.

What is a Standard & Poor's rating

A credit rating is Standard & Poor's opinion on the general creditworthiness of an obligor, or the creditworthiness of issuers of capital market obligations. Over the years credit ratings have achieved wide investor acceptance as convenient tools for differentiating credit quality.

S&P's ratings are based on information provided by the issuer together with other information we consider reliable. Ratings may be changed, suspended or withdrawn because of changes in or unavailability of information.

A rating does not constitute a recommendation to buy, sell or hold a particular security. It does not comment on the suitability of an investment for a particular investor. S&P does not perform an audit in connection with any rating.

What ratings mean

An S & P long-term rating reflects a borrower's capacity to meet its financial commitments on a timely basis. Long-term ratings range from our highest category, 'AAA', to the lowest, 'D.' Ratings from 'AA' to 'CCC.' C Categories may also include a plus or minus sign to show relative standing within the category.

Ratings in the 'AAA,' 'AA,' 'A' and 'BBB' categories are regarded by the market as investment grade. Ratings in the 'BB,' 'B,' 'CCC,' 'CC' and 'C' categories are regarded as having significant speculative characteristics. Ratings from 'AA' to 'CCC' may be modified by the addition of a plus (+) or minus (-) sign to show relative standing within the major rating categories.

A short-term rating is an assessment of the likelihood of timely repayment of obligations considered short-term in relevant markets. Short-term ratings are graded into several categories, ranging from 'A-1' for the highest quality obligations to 'D' for the lowest. The 'A-1' rating may also be modified by a plus sign to distinguish the stronger credits in that category.

Outlooks

An outlook notation indicates the possible direction in which a rating may move over the next six months to two years.

- "Positive": may be raised
- "Negative": may be lowered
- "Stable": unlikely to change
- "Developing": may be raised or lowered

CreditWatch

A CreditWatch listing highlights the potential for near term change in a credit rating. It signals to investors that further analysis is being performed.

WHAT THE "LETTER" RATINGS MEAN

AAA: Extremely strong capacity to meet financial commitments. Highest rating.

AA: Very strong capacity to meet financial commitments.

A: Strong capacity to meet financial commitments, but somewhat susceptible to adverse economic conditions and changes in circumstances.

BBB: Adequate capacity to meet financial commitments, but more subject to adverse economic conditions

BBB- (minus): this is the lowest rating before non-investment grade.

BB: Less vulnerable in the near-term but faces major ongoing uncertainties to adverse business, financial and economic conditions.

B: More vulnerable to adverse business, financial and economic conditions but currently has the capacity to meet financial commitments.

CCC: Currently vulnerable and dependent on favorable business, financial and economic conditions to meet financial commitments.

CC: Currently highly vulnerable.

C: A bankruptcy petition has been filed or similar action taken but payments or financial commitments are continued.

D: Payment default on financial commitments.

NOT-FOR-PROFIT HEALTHCARE RATINGS ACTIONS, OCTOBER 2004

Hospital	State	Rating	Outlook	Action
Asbury Methodist Village Inc. and Asbury Solomons Inc.	MD	BB (SPUR)	Stable	Rating lowered to 'BB' (SPUR) from 'BBB' (SPUR) and outlook is stable
Aspirus Wausau Hospital	WI	A	Negative	New issue; rating affirmed and outlook revised to negative from stable
Baptist Health	AL	BBB	Stable	New issue; rating affirmed and outlook revised to stable from negative
Bloomington Hospital	IN	A (SPUR)	Stable	Rating affirmed
Carle Foundation	IL	AA-	Stable	New issue
Catholic Health Initiatives	CO	AA	Stable	New issue; rating affirmed
Catholic Health Services of Long Island	NY	BBB	Stable	New issue; rating affirmed
Centegra Health System	IL	A-	Stable	Rating affirmed
Centra Health Inc.	VA	A	Stable	New issue; rating lowered to 'A' from 'A+' and outlook is stable
Christian Church Homes of Kentucky	KY	BBB	Negative	Rating affirmed and outlook revised to negative from stable
Christian Health Care Center	NJ	BBB-	Stable	Rating lowered to 'BBB-' from 'BBB' and outlook is stable
Clark Retirement Community	MI	BBB-	Stable	Rating lowered to 'BBB-' from 'BBB' and outlook is stable
Dartmouth-Hitchcock Obligated Group	MA	A+ (SPUR)	Stable	Rating affirmed
Decatur Memorial Hospital	IL	A	Stable	Rating affirmed
Freeman Health System	MO	BBB+	Stable	New issue; rating affirmed
Friendship Village	IL	BB+	Stable	Rating lowered to 'BB+' from 'BBB' and outlook is stable
Froedtert and Community Health Obligated Group	WI	A+	Stable	Rating affirmed
Glen Retirement System	LA	BBB	Stable	Rating affirmed
Greater Fairbanks Community Hospital Foundation	AK	A (SPUR)	Positive	New issue
Hawaii Pacific Health	HI	BBB+	Stable	Rating affirmed
Hope National Medical Center (City of Hope)	CA	BBB	Stable	Rating affirmed
Hospital for Special Care	CT	BB	Negative	Rating affirmed
John C. Lincoln Health Network	AZ	BBB	Stable	Rating affirmed and outlook revised to stable from negative
John Knox Village of Florida Inc.	FL	BBB+ (SPUR)	Stable	Rating affirmed
Kansas University Hospital Authority	KS	A-	Stable	New issue; rating affirmed
Lakeview Village	KS	BB+	Stable	Rating affirmed
Lawrence Hospital	NY	A-	Stable	Rating affirmed
Mary Lanning Memorial Hospital	NE	A- (SPUR)	Stable	Rating affirmed
Masonic Homes of Pennsylvania	PA	A+ (SPUR)	Stable	Rating affirmed
McDonough County Hospital District	IL	A-	Stable	Rating affirmed
Medical Center at Princeton	NJ	A+ (SPUR)	Stable	Rating affirmed and outlook revised to stable from negative
Moses H. Cone Memorial Hospital	NC	AA/A-1+	Stable	New issue; rating affirmed
Mount Clemens General Hospital	MI	BB	Stable	Rating lowered to 'BB' from 'BBB-' and outlook is stable
Nebraska Methodist Health System	NE	A- (SPUR)	Negative	Rating lowered to 'A-' (SPUR) from 'A+' (SPUR) and outlook is negative
Northbay Healthcare System Obligated Group	MD	BBB- (SPUR)	Negative	Rating affirmed and outlook revised to negative
Northwestern Human Services Inc.	PA	BB+	Stable	Rating affirmed
Otterbein Homes	OH	A- (SPUR)	Negative	Rating affirmed
Ozarks Medical Center	MO	BB+	Stable	Rating affirmed
Pickersgill Inc.	MD	A-	Stable	Rating affirmed
Ridgeview Medical Center	MN	BBB+ (SPUR)	Stable	Rating affirmed
Rush Medical Foundation	MS	BBB-	Stable	Rating affirmed
Sentara Healthcare	VA	AA	Stable	Rating affirmed
Skaggs Community Hospital	MO	BBB	Stable	Rating affirmed and outlook revised to stable from negative

A STATE PERSPECTIVE

Reflections on Eber's Private Sector Insights

DID YOU KNOW?

Studies show that 20% to 25% of services for non-elderly adult users of mental health are funded only by Medicaid. Between 7% and 13% of Medicaid enrollees are mental health service users. By 1997, Medicaid spent more than $14 billion that accounted for 20% of all mental health spending and 36% of all public mental health spending in the United States.

Source:
New Freedom Commission
(p 22)

GILMORE

Gary Gilmore, RPh, Deputy Pharmacy Director/ Chief Analyst, Massachusetts Medicaid Office of Clinical Affairs

BASED ON MY EXPERIENCE IN DIRECTING A LARGE STATE PHARMACY program, I want to highlight some of the issues that Bridget Eber has raised in her splendid piece for this issue.

1. Plan design

One key example of an important distinction between private and Medicaid planning is plan design. States are limited in their choice of plan design as a result of federal Medicaid statute found at 1396r of the federal code, informally known as OBRA-90. Provisions of this statute dictate, in part, the plan design a state must follow to participate in the federal Medicaid program to assure federal matching dollars and drug rebates paid by manufacturers. Federal participation in states' Medicaid program is significant, ranging from 50% to 70% of total spend, based on a formula intended to measure a state's financial ability. In addition, the mandated rebate program generates approximately a 20% refund in each state. For these reasons, noncompliance with the OBRA 90 provisions could cost the state a fortune. The combined potential can account for 60% to 80% of total program cost.

GILMORE CONTINUED ON PAGE 15

VADNER

Greg Vadner, MPA, Former Director, Missouri Division of Medical Services

BRIDGET HAS GIVEN US A GREAT OVERVIEW OF THE PRIVATE SECTOR pharmacy purchasing issues and strategies. When we translate this to the world of Medicaid, we run into many hurdles.

- The permissible cost sharing is minimal, and even that is further complicated by the patient's generally low income status.
- Regulations require "open" formularies, although state interpretations have recently weakened that definition to allow for more varied purchasing incentives through aggressive maximum pricing and preferred drug programs.
- Public pharmacy purchasing decisions are under constant pressure from lobby groups from all sides. And difficult hurdles have been established in this process by state regulations, involvement of required drug utilization boards, and other public forum influences.
- Pharmacy for mental health patients is a large part of Medicaid and under constant scrutiny by advocacy groups and relatives of patients who fight most efforts to manage the benefit, claiming that benefits are being denied to those who can least understand and navigate the system's rules.
- The interaction of the drug rebate program in Medicaid further complicates purchasing decisions, often resulting in a Byzantine-like web of little-understood cause and effect.

Into this environment comes the PBM offering understanding and cost savings while promising good management for the public purchasers. A way to outsource a complex political headache while saving money! While pharmacies generally protest, to most, their message seems seductive.

Reflections on Eber's Private Sector Insights

GILMORE CONTINUED FROM PAGE 14

Within the over-all restriction, there are also specific design limitations included in OBRA 90: copay, formulary implementation, or limits on any medication manufactured by a company with a signed rebate agreement with the Secretary for Health and Human Services where medical necessity can be demonstrated. The maximum prescription copay a state can require is $3, however, if the patient states they cannot afford the copay, the pharmacist must still provide the medication free of copay. This small "voluntary" copay maximum negates principles associated with tiered copay as a management tool to shift utilization toward generic or other less expensive alternatives. As a result, states are left with 2 principle management tools—Prior Authorization (PA) and Net Product Cost, which is a pretty limited set of options. In the next few paragraphs, let me give you my sense of these options and their effectiveness, and also comment on some of the detailed strategies available to states.

2. Prior Authorization

Many states have implemented comprehensive prior authorization programs for products found to be a) less effective, b) less safe, or c) more costly. Medicaid prior authorization programs, similar to private sector PA programs, evaluate each request for a drug on the PA list in relation to the diagnostic needs of the patient, while assuring there is not a safer, more effective, less costly alternative available. Most PA models move market share to less costly brands or generics within a therapeutic class that have equal clinical effectiveness. That said, PA programs are expensive to administer and require highly trained support from clinical and legal staff. A properly managed program can result in cost avoidance of nearly 10% when the most appropriate medications are matched to the appropriate patient and diagnosis. Cost avoidance based on drug selection alone is not likely to exceed 10% and can easily cost many millions of dollars to implement depending on the size of the program. The cost-benefit equation can be very hard to balance in this approach.

3. Net Product Cost

Many states, about one-half in the United States, use a "preferred drug list" (PDL) predicated in part on the payment of supplemental rebates by manufacturers. The standard federal rebate is based on the lowest commercial net price available in the marketplace, such that Medicaid federal rebates result in net prices at or lower than any commercial pharmacy benefit management (PBM) in the nation. Supplemental rebate is an additional state negotiated rebate, approved by The Center for Medicare and Medicaid Services (federal) that are exempt from "best price" consideration in setting the federal rebate. Some states choose a few products, while others subject their entire drug list to negotiated supplemental rebates. While these lower the net cost of a product, such deals do not lower the upfront budgeted costs of the product. This can result in increased pharmacy budgets to accommodate payment for expensive brand name drugs that might otherwise be placed on prior approval, while off-setting the higher priced brand with a supplemental rebate to lower the products' price in line with similarly priced products within a therapeutic class, which can be very confusing and labor intensive.

Another way to manage costs is to implement state maximum allowable costs for multi-source drugs. CMS has created federal maximum allowable costs based on 150% markup of the lowest published price generic. Some states have created opportunities to be even more cost aggressive in this area to ensure lowest cost is reimbursed for generic products. The key to this approach is timely data and timely drug file pricing updates to take advantage of lower cost generic drugs. Unlike brand drugs that tend to rise in price over time, generic drugs fall in price. Staying up to date on these changes will result in savings, but this requires constant vigilance.

4. Other Cost Management Tools

As stated in Bridget's article, several other tools used in the private sector have been adopted by states to manage their programs. These include PBM procurement, Specialty Pharmacy contracting, decision support tools, step therapy, early refill management, lock-in

GILMORE CONTINUED ON BACK COVER

DID YOU KNOW?

Successfully transforming the mental health system hinges, in part, on better balancing fiscal resources to support proven, evidence-based practices.

Source:
New Freedom Commission (p.74)

Reflections on Eber's Private Sector Insights

GILMORE CONTINUED FROM PAGE 15

DID YOU KNOW?

The World Health Organization (WHO) identified mental illnesses as the leading causes of disability worldwide. This groundbreaking study found that mental illnesses (depression, bipolar disorder and schizophrenia) account for nearly 25% of all disability across major industrialized nations.

Source:
World HealthOrganization, *The World Health Report 2001–Mental Health: New Understanding, New Hope.*

programs, and prescriber profiling reports. Let me briefly speak to each.

First, PBM procurement in my view has little utility for most states because Medicaid is already guaranteed the lowest price, so product cost will never be lower as a result of PBM involvement. That said, a PBM does bring utilization management expertise to the table that some states simply do not possess internally, or whose programs are too small to justify the amount of staffing needed to properly manage a state program "in-house."

Specialty pharmacy contracting has gained a lot of attention as many biotechnology products require special handling and distribution. These products also tend to be extremely expensive, in some cases > $50,000 per prescription. Utilization of a specialty pharmacy vendor to manage these few, high-cost prescriptions appropriately is generally a good idea in my view.

Decision support tools are critical to managing any program whether commercial or public. It's impossible to manage effectively without extensive command of data, made readily available and translatable by clinically-oriented data managers. Effective use of these tools is central to assuring highest quality care at the lowest cost. Without these tools—in the hands of experts—a state cannot effectively or efficiently employ any management techniques.

Step therapy is one of the most common tools used by states. In this approach, higher priced medications are placed on PA necessitating the use of a less expensive alternative before the higher priced medication will be considered for payment. These are sometimes referred to as "fail first," and Bridget's article raises some important considerations about this approach.

Early refill management is an extremely effective cost avoidance tool when properly executed, making accommodation for elderly and/or clinically fragile patients. Most states find that drugs of abuse are the most common early refill requests due to allegedly lost, stolen, or vacation supply. Many states have effectively closed these loopholes while maintaining safeguards for true need.

Lock-in programs—which means confining a patient to one provider when doctor shopping or substance abuse is evident—does not save much in the cost of medications, but avoids the costs of many unnecessary medical tests while managing the care of patients prone to abuse.

Lastly, prescriber profiling, also known as retro-Drug Utilization Review or physician letter campaigns are highly effective tools that are managed by some states in-house and effectively by other states that utilize companies such as Comprehensive NeuroScience, Inc, with expertise in specific subject areas. These initiatives are entirely educational and helpful to prescribers to better understand best practice and patient compliance. These educational approaches have proven to be highly effective at assuring best practice while saving dollars that otherwise would be wasted.

In summary, the goal of each state should be to seriously evaluate the commercial pharmacy management models and tools and incorporate to the extent possible those that fit a particular states legislative design while staying within the construct of federal statute. No single initiative is either a clinical or fiscal panacea. But, employed in unison with appropriate management tools and staff, a state can have a very effective pharmacy program. Given the limited resources available to states, we really have no other choice.

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General Manager Sarah DeMann, **Associate Editor** Paul W. Mamula, PhD, **Art Direction/Production** Beth Harvey.